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ABSTRACT

Although grief reactions have been carefully examined, little information is available on the grief response following the murder of a loved one. Impressions of homicide survivors' grief reactions were obtained by the staff of a family support center who treated ten families that had experienced the loss of a family member by homicide. Observations of grief were made using Bowlby's three-phase model of the grief response: protest, despair, and detachment. During the protest phase, homicide survivors experienced the characteristic reactions but, in addition, experienced overwhelming rage which often overshadowed feelings of sadness. They also reported a strong urge to seek revenge. Children in this phase demonstrated similar feelings along with regression and severe school problems. The despair of phase two was often increased for homicide survivors because of demeaning experiences with an indifferent police and criminal justice system. Family members lost faith in government and society, and felt more vulnerable and trusted people less. For homicide survivors in phase three, the detachment process was handicapped, particularly in those cases where the murderer had not been apprehended. Other reports of clinical experiences in the treatment of homicide survivors have documented similar results. These findings suggest that the homicide-trauma stress syndrome is a subject in need of both research and preventive psychiatric interventions. (NRB)

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THE GRIEF RESPONSE FOLLOWING A HOMICIDE

by

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Introduction

There is a wealth of literature describing the psychological processes accompanying grief which characterizes the subjective feelings of mourning.[1,2] Although grief reactions following anticipated and sudden death have carefully been examined, relatively sparse information is available analyzing the special features of the grief response following the murder of a loved one or family member.

Clinical Setting

At the Family Support Center within the Judge Baker Guidance Center, our staff provides support and counseling to bereaved families following the death of a loved one or close relative. Over the course of several years, we have evaluated and treated about ten families, including adults and children, that experienced the loss of a family member by homicide. The majority of families were black and Hispanic from low socioeconomic groups. Most were seen within months of the homicide, but several came in for counseling two years after the event and one family sought help ten years after the homicide because of unresolved feelings regarding the father's murder. Six of the homicides involved children, two were age five and fifteen and the rest over age eighteen. The other victims were parents. In one case, two young children apparently witnessed the stabbing death of their father by their mother.

Information about family reactions and responses was obtained clinically during the process of evaluation and counseling. No structured, systematic, research oriented attempt was made to collect data. Material about symptoms, signs, and course of progress was obtained from case presentations and the clinical record. Some families did not return after a few initial visits while others were counseled over a long term. As a result, our information is sketchy

in some instances and detailed in others. Nonetheless, we were able to gain impressions of the homicide survivor's acute reactions and examine how they differed in degree and kind from the typical grief response.

Clinical Findings

Using Bowlby's three phase model of the grief response, we will present for discussion our observations on grief using this model in order to examine the similarities and differences from the usual grief reaction in both adults and children.[3]

Bowlby's first phase was termed protest, in which instinctual responses remained focused on the lost object. During this phase, there is a strong wish for reunion with the loved one and there are feelings of disbelief and numbness followed by weeping and anger. During this stage, characteristic somatic symptoms also occur such as palpitations, headaches, insomnia, nightmares, and gastrointestinal upsets. Our clients displayed these characteristic reactions, but we observed, in addition, that the rage in homicide survivors was overwhelming, prolonged, and often markedly overshadowed feelings of sadness. Family members felt criminally violated much as rape victims report.[4] In addition, there was a strong urge, accompanying the feelings of rage, to seek revenge. In several cases, family members obtained weapons and during phase one hunted for the killer. Many clients during phase one also exhibited a sense of terror and fear of the environment which was exaggerated compared to the usual grief response.

Children demonstrated many of the above symptoms as well, but also showed regression characterized by hyperactivity, loss of ability to concentrate, bedwetting, fears of being alone and increased aggressiveness. Several developed severe school disturbances. During phase one both adults and children appeared

overwhelmed, demanding great nurturing and support from family and friends.

Bowlby's second phase of mourning was termed despair. This stage is characterized by disorganization of the personality accompanied by pair and despair. During this period, persons accept the reality of the death but the bereaved continue to experience restlessness, anxiety, and depression. In our subjects, phase two was complicated by continued strong feelings of rage, guilt, and the wish for vengeance. Despair was often increased because of experiences with the police and criminal justice system which clients felt were indifferent and demeaning. One mother in our group suffered severe depression because a police investigation was not conducted of her son's murder until several months after the homicide when our group intervened and advocated on her behalf. Her depression lifted immediately when homicide detectives became interested in her case.

As a result of such experiences, more depression was felt because family members lost faith in the order of government and society, felt more personally vulnerable, and in general, felt less trust in people. Adults caught in this emotional state were often not psychologically available to give needed support to children, thereby arresting the natural flow of their mourning process as well. The homicide event was profoundly disruptive of the families' security within the environment and, thereby, complicated an easy transition to Bowlby's phase three of the mourning process.

The third stage has been termed detachment and is one in which reorganization takes place. The bereaved detaches himself from the lost object and begins to develop new ones or substitutes. Dysfunctional behavior markedly diminishes, and the sufferer is able to reintegrate his life within the family and society. Many may recognize that the lost object can never be completely

replaced,particularly if it is a child. Similar transitions took place in our clients but detachment was handicapped,particularly in those cases where the nomicide perpetrator was not apprehended. In these instances, there was preoccupation with the homicide, and feelings of being psychologically violated persisted. Despite these emotional obstacles, children and parents whom we counseled made progress in the mourning process with our support and therapy. Also, the greater resiliency of children was apparent in their rebound and recovery, but we could only wonder whether the homicide event would place them at risk emotionally at some time in the future.

Discussion

The literature detailing the grief response in families of homicide victims is sparse and what does exist is of relatively recent origin. The new attention being given by social agencies to homicide survivor families is largely a result of growing concern with the damage inflicted on victims of crime and violence in American society. Victim-witness protection programs have encouraged the interest of both legal and social service agencies in the support of those who experience such traumas.

Additionally, a growing interest in preventive approaches to mental health problems has motivated many psychiatrists, psychologists, social workers, and lawyers to offer counseling services to victims to obviate future psychological dysfunction, particularly in traumatized children.

The material that does exist in the literature on family responses to homicide can be divided conveniently into those papers that focus on adult reactions and those that focus on the effects on children.

Burgess (1975) conducted a pilot study of nine cases of family members of white middle-class nomicide victims in which she identified a two-phased

homicide-trauma syndrome experienced by survivors.[5] The immediate crisis phase she described as an acute grief process, that included reactions to the murder, the funeral details, and police investigations. The second phase she called the long-term reorganization phase during which the family members dealt with the on-going psychological issues of bereavement and the socio-legal issues of the criminal justice process.

Burgess' description of the acute grief process is similar to Bowlby's phase one and coincides with our findings. Besides the sense of loss, there was a sense of horror in these individuals at the manner of death, and pre-occupations with the victim's suffering and disfigurement. Also during the acute phase, families experienced feelings of profound helplessness associated with deep and prolonged feelings of anger and outrage. Accompanying these emotions were strong wishes for revenge and retribution. She found, as we did, that such emotions do not usually characterize the grief response which follows an anticipated death or even a sudden accidental death.

Other signs and symptoms reported by Burgess were similar to those following a sudden death, with a few notable exceptions. Her subjects experienced the typical psycho-somatic symptoms, numbness, confusion, insomnia, nightmares, headaches, chest pain, palitations and gastrointestinal upsets. Yet, she did not report fear as a prominent feature of the typical acute phase but described phobic reactions in several subjects. A few family members became more aware of potential danger in the environment and took precautions to better protect themselves, including obtaining permits to carry guns. It was clear that her families felt violated and their faith in the world as a secure and ordered place was undermined. She noted that a critical part of the reorganization phase

for families following a murder is the reestablishment of trust and faith in the world, society, and people.

Bard and Connolly (1980) conducted a retrospective study of surviving family members of mostly black and Hispanic homicide victims and attempted to compare reactions to this form of sudden death to those of suicide and motor vehicle fatalities.[6] All deaths had occurred two years earlier so that clients' retrospective reports of symptoms and reactions may not be completely reliable. Thirty-nine interviews were conducted in all three categories, eighteen were of family survivors of homicide victims.

The authors did not describe their subjects' retrospective recollections in the usual language of the grief response. They reported that half the subjects showed evidence of Post Traumatic Stress Disorder during the six to twelve months following their relative's death. This severe reaction was not reported to be more common among homicide survivors than the other groups. A majority of subjects also reported short-term somatic symptoms but homicide survivors had a slightly greater tendency to report current somatic symptoms than the other two sudden death groups. In our clinical examination, although stress on clients was overwhelming, none met the full criteria for Post-Traumatic Stress Disorder as outlined in DSM-III (p.238).

The authors confirm our observations in their report that during the first year, two-thirds of the subjects felt angry or hated the person responsible for the death, and that revenge (if only in thoughts) was often sought. Attempts to grade the level of anger were not undertaken and distinctions among the three groups were not apparent. The authors also wondered about cultural differences in their subjects' reactions to homicide and its social consequences. Bard

and Connolly's work is important, despite its methodological difficulties, because of its attempt to formulate a research design with appropriate control groups to gain greater understanding of the special features of the homicide-trauma syndrome.

A recent report by Getzel and Masters (1984) is of special interest because the authors were engaged in a Victim Services Agency in New York City that provided help to 356 mostly black and Hispanic families of homicide victims.[7] They reported that sixty percent of services requests for assistance were for financial entitlements and public welfare. Approximately thirty percent presented with acute grief reactions and the dysfunctional behavior of children and other relatives. They state: "The depth of emotional reactions was overwhelming and cannot be overstated."[8] They reported that clients were in deep shock and apathy (i.e. numbness) and displayed helplessness, terror, consuming rage, guilt, and intense yearnings for the dead. Parents of murdered children tended to have the strongest grief reactions which lasted for many months. The authors reported too that many of these families voiced direct appeals for assistance to cope with the criminal justice system. Usually families saw the criminal justice system as an indifferent and/or demeaning experience which worsened their grief and anxiety thus compounding their sense of family disorder. Many of our clients had similar encounters and reactions to the criminal justice system.

Besides individual counseling, the authors provided homicide survivor support groups to facilitate mourning and the reorganization of the family. They observed that questions unique to homicide: -- Who is the perpetrator? How could the murder have been prevented: -- are recurrent questions which interfere with the progress of bereavement. Some of these support groups evolved

into political action programs advocating for the rights of families of homicide victims and making recommendations for homicide prevention programs. These investigators felt that the survivors' support group approach is most useful for reintegration of the bereaved and avoids an exclusive, and sometimes stigmatizing, focus on individual reactions and psychopathology.

While the reactions of adults to the murder of a family member are overwhelming, we can expect a devastating effect as well on surviving children, particularly if they have witnessed the murder. We and others have noted that there appears to be some professional neglect of children traumatized by a family homicide and, consequently, only a few reports appear in the literature, even though Pynoos and Eth report that of 2000 homicides in Los Angeles County in 1981, about ten percent involved children as witnesses.[9]

Pruett (1979) reported on a home-based treatment program of eleven sessions for two preschool siblings who had witnessed the murder of their mother by their father, and then saw the father shoot himself in an attempted suicide.[10] (This case is similar to the one on our sample in which two young brothers witnessed the stabbing death of their father by the mother.) Pruett reports severe trauma, regression, confusion, and dysfunction in the two children, ages two and three. They had extreme fear as well as nightmares. The children soiled themselves and the youngest temporarily loss her speech. These children were fortunate to be cared for by a loving grandmother who, nonetheless, needed much help in responding honestly to the death, and cause of death, of the mother. The author states, "...a nonpunitive, affectively supportive response seems as significant as factual content in assisting the young ego to cope with massive trauma."[11] He suggested that crisis intervention work was critical to the future well-being of children who have witnessed or experienced a family

homicide, particularly that of a parent.

Similarly, Zeanah and Burk (1984) reported on the treatment of a four year old girl who apparently watched her father strangle her mother to death.[12] The girl experienced the extreme anxiety, fear and regression which is common with this magnitude of loss, trauma, and conflict. The author likened her symptoms to a post-traumatic stress disorder.

The young patient had loving foster parents who were actively involved in the treatment which continued for twelve weekly sessions. A trusting relationship with a caring adult who also serves as a model was considered to be a critical factor in the successful outcome of this case. Zeanah and Burk, as did Pruett, recognized that such childhood trauma was not uncommon and strongly recommended that these children receive psychiatric treatment as children-at-risk. Our limited observations of such children exhort us to concur with their recommendations.

Conclusion

The grief response in a family following a homicide of a loved one or family member is usually overwhelming and atypical. In addition to the usual symptoms of grief, the survivors have great rage, vulnerability, distrust, fear, and a wish for revenge which may impede the grief process and cause the reorganization stage to be much more difficult as they struggle with their own despair and often unpleasant experiences with the criminal justice system.

Children experiencing such trauma are particularly vulnerable and require crisis intervention and support.

Based on our clinical experiences and those of others, we feel that the homicide-trauma stress syndrome is a fruitful subject for research as well as

a clinical area requiring significant preventive psychiatric interventions. We have found a family approach works well but individual treatment is often necessary and useful.

We agree with the four service approaches recommended by Getzel and Masters:

- Case advocacy and brokering for needed services and entitlements when family function is in disarray.
- Short and long-term family counseling to deal with the immediate and enduring consequences of the homicide on individual kin and the kinship system.
- Support groups for parents of homicide victims to address their social isolation and recurrent grief reactions (we suggest that such groups would be helpful to children as well).
- Social action activities to interpret families' criticism of the procedures of the criminal justice system and to press for reforms.

Mental Health professions, in particular, are in a position to develop multidisciplinary programs to serve these traumatized families and children in order to ease their stress and dysfunction.

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